Handbook for Providers of Screening, Assessment and Support Services

Chapter CMH-200 Policy and Procedures For Screening, Assessment and Support Services

CHAPTER CMH-200

SCREENING, ASSESSMENT AND SUPPORT SERVICES

TABLE OF CONTENTS

APPENDICES

GLOSSARY OF TERMS

Administrative Case Review: A review of permanency planning open to the participation of the parents of the child conducted by a person who is not responsible for the case management of the child or for the delivery of services to either the child or the parents who are subject to the review. The review is also open to the participation of other professionals involved in assessing or treating the child, any legal representative of the parent or child and the foster parents as specified in DCFS Rule Section 316.50.

CASSP (Child and Adolescent Service System Program): A concept developed through the federal Child and Adolescent Service System Program based upon the core values that the system of care should be child-centered and family-focused, community-based and culturally competent.

CARES (Crisis and Referral Entry Service): A single point of entry to the SASS system that provides telephone response and referral services for children requiring mental health crisis services.

CARTS (Comprehensive Assessment Responsive Training System): an innovative collaborative assessment and treatment program that addresses the needs of severely ill wards of the State of Illinois.

Case management: Services to provide linkage, support and advocacy for persons with mental illness or behavioral disorders who need multiple services and require assistance with gaining access to and in using mental health, health, social, vocational, educational and other community services and resources.

CATU (Children & Adolescent Treatment Unit): A nine-bed inpatient psychiatric unit that is part of the CARTS. CATU treats DCFS wards who have had several psychiatric hospitalizations, numerous placements, and who are severely aggressive. Hospitals throughout the state make referrals when they are unable to manage or treat these wards. SASS, DCFS staff, residential programs and other service providers also make referrals to the CATU. All referrals go to the DCFS Gatekeeper for approval, and approval is given after consultation with the CATU psychiatrist.

CCBYS (Comprehensive Community-Based Youth Services): A statewide program serving youth ages 10-17 who are at risk of involvement in the child welfare and/or the juvenile justice system. The primary purpose of CCBYS is to provide at-risk youth with a continuum of services according to their needs, with the overarching goal of family preservation, reunification or independence, again depending upon the youth's need. Such services are directed at assuring that youth who come in contact with the child welfare or juvenile justice systems will have access to needed community, prevention, diversion, emergency or independent living services.

Certification: The initial determination and redetermination by DCFS or DHS of the eligibility of a provider to participate in the 59 Ill. Adm. Code 132, Medicaid Community Mental Health Services Program, and to provide mental health services.

Community-based services: Social services provided in the home, school or other community-based location to children with a serious emotional disturbance or mental illness and to their family to reduce the risk of more restrictive treatment, such as psychiatric hospitalization.

CMHP (Community Mental Health Provider): An agency certified by DHS or DCFS and enrolled with DPA to provide Medicaid community mental health services in accordance with 59 Ill. Adm. Code 132.

CSPI (Childhood Severity of Psychiatric Illness): A screening tool used for children with emotional and behavioral disorders. The CSPI is a measure of psychiatric severity and is used as part of the assessment to determine if a child should be hospitalized or can be safely maintained in the community (Lyons, Mintzer, Kissiel, & Shallcross, 1998).

Culturally competent: The effort to understand and be responsive to cultural differences of children and their families.

Departments: DCFS, DPA and DHS, may also be referred to as “the State”.

DCFS: The Illinois Department of Children and Family Services.

DCFS System of Care Program (SOC): A statewide network of DCFS-funded, community-based providers responsible for placement stabilization services to targeted children under the care of DCFS. This program is (1) a comprehensive spectrum of mental health and other support services that is organized into a coordinated network to meet the multiple and changing needs of wards with serious emotional disturbances and their families, and (2) available to provide intensive home-based services to wards who are at risk of losing their current placement.

DCP: The Division of Child Protection within the Illinois Department of Children and Family Services.

DHS: The Illinois Department of Human Services.

DMH: The Division of Mental Health within the Illinois Department of Human Services.

DPA: The Illinois Department of Public Aid.

Eligible Child: Any child who is referred to a SASS provider by CARES.

FRD (Family Resource Developer): A previous SASS consumer or a parent/guardian/caregiver of a child who has navigated the mental health system successfully and has the skills to assist other families/parents or caregivers who is

employed by a SASS agency. The FRD may help with logistical planning, overcoming obstacles, addressing stigma and providing support to the child and family.

FLEX Funds: Funds used to augment traditional mental health services where additional and alternative therapeutic supports are needed and no other funding source is available. Services, which can be funded through the use of "FLEX funds", are identified in Topic CMH-202.3 of this handbook.

Forensic: Forensic SASS children are juveniles adjudicated under Illinois Criminal Statutes as Unfit for Trial (725 ILCS 5/104 10 - 31), or Not Guilty by Reason Of Insanity (730 ILCS 5/5-2-4). Juveniles judged to be Unfit for Trial may be remanded to the Department of Human Services for fitness restoration services on an inpatient or outpatient basis. Juveniles acquitted of their charges by Reason of Insanity are ordered to the Department of Human Services for an evaluation to determine if they are: 1) subject to involuntary admission: 2) in need of mental health services on an inpatient basis: 3) in need of mental health services on an outpatient basis or: 4) not in need of mental health services. Juveniles committed to inpatient care under the Insanity Statute are treated in a secure facility until the court determines that they can be placed in a less restricted setting or conditionally released into the community.

Guardian: The court-appointed guardian of a person under the Probate Act of 1975 [744 ILCS 5] or a temporary custodian or guardian of the person of a child appointed by an Illinois juvenile court or a legally appointed guardian or custodian or other party granted legal responsibility.

HIPAA (Health Insurance Portability and Accountability Act): A Federal law that makes a number of changes that have the goal of allowing persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives the Department of Health and Human Services the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information.

ICG (Individual Care Grant): A grant administered by the Illinois Department of Human Services, which provides funding for intensive community-based services or residential placement for children and adolescents who meet specific eligibility criteria as defined in Ill. Adm. Code 135.

LAN (Local Area Network): Identified geographic boundaries across the state of Illinois. The LAN map can be found on DPA's Web site. Refer to Appendix CMH-8.

LPHA (Licensed Practitioner of the Healing Arts): An individual who, within the scope of State law, has the ability to independently make a clinical assessment, certify a diagnosis and recommend treatment for persons with a mental illness.

Mental Health and Developmental Disabilities Code: Legislation that protects the rights of individuals in the mental health system [405 ILCS 5].

Mental Health and Developmental Disabilities Confidentiality Act: Legislation that protects the right to confidentiality of individuals in the mental health system [740 ILCS 110].

Mental Health Assessment: The formal process of gathering into a written report(s) demographic data, presenting problems, history or cause of illness, history of treatment, psychosocial history and current functioning in emotional, cognitive, social and behavioral domains which results in identifying the client's mental health service needs and in recommendations for service delivery, and may include a tentative diagnosis.

MHP (Mental Health Professional): An individual who provides services under the supervision of a QMHP and who possesses a bachelor's degree or at least five years of experience in human services.

Provider: An agency certified by DHS or DCFS to provide Medicaid community mental health services in accordance with 59 Ill. Admin. Code 132.

QMHP (Qualified Mental Health Professional): As defined in 59 Ill. Adm. Code 132.25, a QMHP is a Licensed Practitioner of the Healing Arts, Licensed Social Worker, Registered Nurse, Occupational Therapist or an individual possessing at least a master's degree in counseling and guidance, rehabilitation counseling, social work, vocational counseling, psychology, pastoral counseling, or family therapy or related field, who has successfully completed a practicum or internship that included a minimum of 1,000 hours of supervised direct service, or who has one year of clinical experience under the supervision of a QMHP.

RIN (Recipient Identification Number): Unique 9-digit number assigned to each person who receives medical benefits from the state. The number is utilized by DPA to identify and pay medical bills to providers.

Rule 132: 59 Ill. Adm. Code 132, Medicaid Community Mental Health Services.

SASS (Screening, Assessment and Support Services): A program of intensive mental health services provided by an agency to provide pre-admission screening, crisis stabilization and follow-up services to children with a mental illness or emotional disorder who are at risk for psychiatric hospitalization.

System of Care: A comprehensive spectrum of mental health and other support services that is organized into a coordinated network to meet the multiple and changing needs of children with serious emotional disturbances and their families.

FOREWORD

The *Children's Mental Health Act of 2003*, Illinois Public Code 93-045, represents a significant opportunity for Illinois to promote the well-being of children by maintaining them in the least restrictive settings, working with families in their home(s) or other natural environments, providing culturally and linguistically competent services, maintaining normalizing routines and activities, and allowing for earlier interventions to address growing problems. A requirement of the Children's Mental Health Act of 2003 is to ensure the screening and assessment of children and adolescents prior to any admission to a hospital for inpatient psychiatric care for all children eligible for the Department of Public Aid's (DPA) medical programs. With the passage of this Act, DPA joined two other Illinois State departments who have been funding screening and assessment services for children since 1992: the Department of Human Services (DHS) and Department of Children and Family Services (DCFS). The three State Departments (hereinafter referred to as Departments) are now collaborating to implement the Children's Mental Health Screening Initiative through the Screening, Assessment and Support Services (SASS) Program.

This statewide initiative will: (1) provide screening, assessment and treatment of any child who may be at risk of psychiatric hospitalization and who is eligible for public funding under any program funded by one of the three collaborating Departments; (2) enhance access to coordinated community-based mental health services either in lieu of or following in-patient care and screening; and (3) effectively link families and guardians to the appropriate level of care to meet the mental health treatment needs of a child.

PROVIDER GOALS

- Participate in the establishment of a single coordinated and cohesive service system for children.
- Ensure that families experience less fragmentation when trying to access services.
- Utilize and enhance early community-based interventions and provide care coordination.
- Provide comprehensive, coordinated community-based treatment services in-lieu of hospitalization.
- Recommend hospitalization only when community resources are not available or appropriate so that children will be less likely to experience an unnecessary hospitalization.
- Actively participate in hospital staffings and discharge planning to assure a seamless transition into the community.
- Reduce recidivism and length of stay in psychiatric hospitals.
- Provide advocacy and support for children, parents, caregivers and guardians.
- Provide alternative supports that will coalesce around the needs of children (e.g., education, juvenile justice, alcohol and substance abuse and developmental disabilities).

HANDBOOK USE

Providers will be held responsible for compliance with all policy and procedures contained herein. Failure to comply may result in sanctions, up to and including termination of the contract for SASS services. This handbook has been prepared for the information and guidance of SASS providers and other Community Mental Health Providers who render services to children in the Departments' SASS program. It also provides information on the DPA requirements for provider participation, enrollment and billing. This handbook can be viewed on the DPA Web site at:

http://www.dpaillinois.com/handbooks/

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the SASS program requirements regarding service delivery as well as the DPA billing procedures. Revisions in and supplements to the handbook will be released as operating experience and state or federal regulations require policy and procedure changes in the Departments' SASS program. The updates will be posted to the DPA Web site at:

http://www.dpaillinois.com/cmhp/

CHAPTER CMH-200

SCREENING, ASSESSMENT AND SUPPORT SERVICES

SECTION I. PROGRAMMATIC RESPONSIBILITIES

CMH-200 SASS PROGRAM ELIGIBILITY

CMH-200.1 ACUITY ASSESSMENT

CARES will perform an acuity assessment for calls denoting a psychiatric crisis or asking for SASS services. If the acuity assessment determines a need for SASS services and the child/family meet the age and financial assessment criteria (see below), CARES will refer the call to a SASS provider for screening. The caller should be prepared to provide details regarding the nature of the mental health crisis the child is currently experiencing.

CMH-200.2 AGE AND FINANCIAL ASSESSMENT

The caller should be prepared to provide to CARES demographic details regarding the child, such as age, any insurance information available as well as home address, location of the crisis, etc. The following criteria will be applied to determine age and financial eligibility:

- Children under the age of 18 seeking public funding for psychiatric services through DHS.
- Children and adolescents under the age of 21 enrolled in DPA's medical programs, including KidCare.
- Any person for whom DCFS has legal responsibility.

Included in the three categories listed above are Illinois children residing in the contiguous counties of bordering states and any child hospitalized in another state and transferring to a hospital in Illinois or into a hospital within a contiguous county that borders Illinois for an initial screening.

For children with dual insurance (Medicaid as the secondary), CARES should be called at the time of a psychiatric crisis. CARES will enter a prior approval for the SASS provider and will authorize 90 days of SASS eligibility if the child meets the acuity screening. Medicaid should always be billed as the payer of last resort. Refer to Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures, Topic 120.

Children enrolled in a Medicaid Managed Care Organization (MCO) or under the KidCare Rebate, are not eligible for SASS services and will not be entered into the SASS system by CARES.

CMH-200.3 ACUITY AND ELIGIBILITY REVIEW AND APPEAL

CARES will automatically review any ”marginal” referrals: That is, any referrals whose acuity falls within the marginal range (as determined by the Departments) will receive an automatic supervisory review.

Any caller that would like to appeal the decision of CARES regarding eligibility may contact CARES and ask for additional review of the referral. CARES will then review the referral and coordinate with the Departments, as needed, regarding final disposition of the referral.

CMH-200.4 NOTICE OF SASS TEMPORARY ELIGIBILITY

Children under the age of 18 seeking public funding for psychiatric services through DHS are the only children for whom a Notice of Temporary Eligibility will be issued by CARES. Children already enrolled in one of the Medical Assistance Programs will not receive a Notice of Temporary Eligibility. The Notice of Temporary Eligibility is used to identify the child’s eligibility for services through the SASS program. CARES will assign the child a RIN and fax the Notice of Temporary Eligibility to the SASS provider within 24 hours of the initial referral for a screening and assessment being made. SASS providers should give the Notice of Temporary Eligibility to the child’s parent of guardian as soon as possible, as it will be used to access services (e.g., limited pharmaceuticals or transportation to medically necessary mental health services).

If a child with temporary eligibility is hospitalized, the hospital is responsible for assisting the family with submitting a Medicaid application. SASS providers should assist the families of non-hospitalized children with temporary coverage in submitting a Medicaid application. Information on applying can be found on DPA’s Web site. Refer to Appendix CMH-8.

CMH-201 PRIOR APPROVAL PROCESS

CMH-201.1 SASS SERVICES

CMH-201.11 Initial SASS Referral

Prior approval is required for a child to be admitted into the SASS program and to receive SASS services. The Departments contract with Westside Youth Network, the Crisis and Referral Entry Service (CARES), to process prior approvals for admission into the SASS program and to authorize SASS services. To request a prior approval, contact CARES at 1-800-345-9049, TTY 1-800-905-9645, any time, seven days a week, 24-hours a day.

> If subsequent psychiatric crises occur that necessitate another SASS screening, the SASS provider does not need to call CARES for additional authorization **as long as** the child is still eligible for SASS services.

If CARES determines that the case is appropriate for a SASS referral, a prior approval for admission into the SASS program is entered into DPA's system at the time a child is referred to the SASS provider. This initial prior approval authorizes the delivery of SASS services for a period of 90 days. The SASS provider will receive a prior approval letter from DPA showing the 90-day SASS eligibility period. The initial prior approval only authorizes services to be rendered by the SASS provider receiving the referral from CARES. The begin date of eligibility on the prior approval letter should be the date the CARES referral was made. Discrepancies should be reported to CARES.

> A monthly eligibility report will be sent to SASS providers detailing every child with active eligibility in SASS for their agency. SASS providers are responsible for reviewing this list and contacting CARES at 800-345-9049 if there are any discrepancies between the eligibility report and the SASS provider's records.

CMH-201.12 SASS Provider to SASS Provider Transfers

All transfers from one SASS provider to another SASS provider must be registered with CARES. The referring SASS provider must contact CARES to register the receiving SASS provider with CARES. This registration by CARES is required in order for the receiving SASS provider to be paid for services rendered. The receiving SASS provider will receive a prior approval letter from DPA indicating the begin date for the prior approval. A transfer between SASS providers does not extend the initial 90-day authorization time period.

CMH-201.13 SASS Referral to Other Service Providers

Prior approval is required when a SASS provider links a child to additional service providers. As with a SASS provider to SASS provider transfer, the referring SASS provider must contact CARES to register the new service provider. This registration by CARES is required in order for the new service provider to be paid for services rendered. The new service provider will receive a prior approval letter from DPA indicating the begin date for the prior approval.

CMH-201.2 NON-EMERGENCY TRANSPORTATION SERVICES

CMH-201.21 General Parameters

DPA contracts with First Transit, Inc. to provide prior approvals of requests for **non-emergency** transportation services throughout Illinois. This process is separate from the CARES prior approval process. To request a prior approval for non-emergency transportation services, contact First Transit, Inc. at 1-877-725-0569, TTY 1-877-204-1012, Monday - Friday 8:00 AM - 5:00 PM.

> Transportation guidelines are provided in Chapter T-200, Handbook for Provider of Transportation Services. The handbook can be found on DPA's Web site. Refer to Appendix CMH-8.

All non-emergency transportation requires prior approval. Exceptions to this policy can be found in Topic T-211 of the transportation handbook.

Requests for approvals must be made at least two business days prior to the date the transportation service is needed. "Business day" means Monday through Friday and does not include Saturdays, Sundays and state holidays.

The parent, caregiver, transportation provider, medical services provider or the SASS provider must initiate a request for transportation to First Transit. For DCFS children, this request may only be made by the SASS provider.

> Transportation to a pharmacy is not a covered service. Refer to Topic T-204 of the Handbook for Providers of Transportation Services.

Approval will be given for the least expensive mode of transportation, which is adequate to meet the child's medical/behavioral health needs on the date of service. The Departments reserve the right for First Transit to determine the appropriate mode of transportation and, if necessary, to assist in obtaining a transportation provider for the child.

First Transit will require the following information to determine whether the requested transportation is approved:

- Name of the child needing transportation.
- Child's Recipient Identification Number (RIN).
- Date and time of the medical appointment.
- Medical provider name and address.
- Specific purpose of the appointment.
- Information to determine the level of transportation needed.
- Transportation provider name and provider number.

In the event it is not possible to obtain prior approval for non-emergency transportation, post approval must be requested within 15 days of the date of service. The post approval requirements are described in Topic T-211.2 of the Handbook for Providers of Transportation Services.

Authorization for non-emergency transportation services does not transfer from one provider to another provider.

CMH-201.22 Standing Approvals

During the 90-day authorized SASS period, a standing approval may be obtained when multiple trips to the same medical/behavioral health source are required based on standing orders for specific medical/behavioral health services. Pursuant to Topic T-211.1 of the Handbook for Providers of Transportation Services, to request a standing approval, the child's physician, SASS provider or other health professional must supply First Transit with a written statement describing the nature of the medical/behavioral health need, the necessity for on-going visits, already established appointment dates and the number and expected duration of the required on-going visits.

CMH-202 SASS CORE SERVICES

Services and materials must be provided in accordance with the limitations and requirements described within this handbook and the contract for participation in the SASS program. The SASS services listed in this section will be reimbursed through DPA's fee-for-service system.

> All SASS services require prior approval. Refer to Topic CMH-201, for information regarding prior approval.

CMH-202.1 SCREENING AND ASSESSMENT SERVICES

CMH-202.11 Telephone Contact via CARES

The SASS provider shall respond immediately to all calls/pages received from CARES, but no longer than 30 minutes. If the on-call SASS worker has not returned the call from CARES within 30 minutes, CARES will call the SASS provider's emergency back-up number.

The SASS provider shall obtain preliminary information from CARES concerning the nature of the crisis.

CARES will verify Medicaid eligibility for all children referred to a SASS provider. Children without Medicaid eligibility will be assigned a RIN by CARES and a Notice of Temporary Eligibility will be sent to the SASS provider. Refer to Topic CMH-200.4.

CMH-202.12 Screening and Assessment

CMH 202.12.1 Response Time

Emergency Response: Emergency referrals from CARES will involve a child in crisis who is at risk of hospitalization. The SASS provider must arrive at the site where the crisis is occurring within 90 minutes of receiving the emergency referral from CARES.

Non-Emergency Response: For non-emergency referrals received from CARES the SASS provider must provide a face-to-face screening and assessment within 24 hours of receiving the call, or if the child is hospitalized, prior to discharge. Non-emergency referrals include SASS evaluations for services such as CATU, forensic cases, transfers from LAN to LAN, a hospitalized child with private pay or insurance who becomes eligible for SASS as under-insured and children, who due to an imminent medical condition or severe risk of self-harm are admitted prior to the hospital calling CARES.

CMH-202.12.2 Screening Location

The SASS provider shall perform the screening at a location that is best for the child, **not** the SASS staff. The preferred location for the screening and assessment is where the crisis is occurring. If an on-site crisis screening and assessment pose a threat to the physical safety of the SASS worker, then law enforcement support or identification of an alternate resource should be utilized to allow for the crisis screening and assessment to occur. The SASS worker will communicate to the family/caller the details regarding when, how and where the screening and assessment will occur.

Children with temporary eligibility do not have coverage for emergency room services. Therefore, emergency rooms should not be utilized as meeting places, unless the child has initially presented at an emergency room.

CMH-202.12.3 Consent

Consent is not required for emergency response screenings.

Consent is required for all non-emergency response screenings. The SASS provider must inform the child's parent, guardian or caregiver of the screening and assessment and obtain the appropriate consents prior to meeting with the child, as applicable. The SASS provider must also include the child's parent, guardian or caregiver during the screening, assessment and disposition of the crisis situation, or as soon as possible if not immediately available.

CMH-202.12.4 Assignment of SASS Provider

The SASS provider serving the LAN in which the child is experiencing a crisis shall be contact by CARES to respond and complete the face-to-face screening and assessment.

- If the SASS provider responding to the crisis is not the child's home SASS provider, then the responding SASS provider is responsible for collaboration with the child's home SASS provider when determining and completing the disposition plan.
- **The child's home SASS provider must be involved in disposition planning during the crisis screening and assessment (e.g., via phone consult).**
- The SASS care coordination and intensive outpatient services shall be transferred to the home SASS provider as soon as the crisis is stabilized or as agreed upon by both SASS providers.
- The screening details shall also be communicated to the home SASS provider.

CMH-202.12.5 Screening and Assessment Requirements

The SASS face-to-face screening and assessment shall minimally include the following:

- Childhood Severity of Psychiatric Illness (CSPI) decision support instrument. Refer to Appendix CMH-8. For the 18-21 year-old populations, some portions of the CSPI should be decided on a case-by-case basis regarding its relevance (e.g., Caregiver items), since those same items will be relevant to some 18-21 year olds.
- A mental status evaluation.
- An evaluation of the extent of the child's ability to function in his/her environment and daily life.
- An assessment of the child's degree of risk of harm to self, others or property.
- A determination of the viability of less restrictive resources available in the community to meet the treatment needs of the child. If a child presents in crisis outside of his/her home LAN, the home LAN SASS provider **must** be consulted via phone prior to determining the disposition of the screening.

The SASS face-to-face screening and assessment disposition shall be completed within 4 hours of the CARES referral. The response time and case disposition shall be reported within 72 hours to the Departments' authorized agent, Northwestern University, by faxing the completed CSPI summary to 312-503-0425, or in the manner specified by the Department.

The 90-day SASS service period begins with the date CARES enters into DPA's prior approval system. If subsequent psychiatric crises occur that necessitate another SASS screening, the SASS provider does not need to call CARES for additional authorization, **as long as** the child is still eligible for SASS services (i.e., within the 90-day eligibility period or if eligibility has been extended via an approved extension request).

= SASS completes the first CSPI at the initial face-to-face pre-psychiatric hospital screening, any subsequent screenings, and when SASS discharges a client from the SASS program

SASS services are limited to 90 days, unless an extension is approved by the Departments, regardless of the number of hospitalizations during that time period. Information on extensions can be found in Appendix CMH-5.

Hospitals are required to call CARES prior to each admission, even if the admission occurs within an approved 90-day period.

CMH-202.13 Determination

The SASS provider should consider the following factors when making a determination to utilize crisis stabilization and community resources to meet the immediate needs of the child or to facilitate psychiatric hospitalization:

- Is the child's behavior due to missed medications (whether non-compliance, missed doses or out of medication)?
- Is the child's behavior due to an imminent threat of harm from others?
- Is the child displaying aggressive and/or dangerous behaviors that are likely to cause harm to self or others, even if that is not the intent?
- Is the child displaying aggressive behaviors with a plan and/or means to carry out the plan?
- Is the child actively suicidal/homicidal with a plan and/or means to carry out the plan?
- Is the child psychotic or displaying dissociative behaviors that are likely to require hospitalization in order to stabilize and/or to prevent harm to the child, self or others?
- Is the family/guardian or caregiver able to emotionally support, supervise or safely monitor the child?
- Is there a significant past history of one of the following risk factors: aggressive, dangerous, psychotic or dissociative behaviors, suicidal/homicidal ideation or severe depression and inadequate family or community supports?
- Is the child currently being served by a mental health provider and is there an opportunity for consultation?
- Is the SASS provider able to mobilize community and family resources to ensure crisis stabilization in a safe and timely manner?

The disposition of the screening should be recorded on the CSPI Summary Form. The CSPI Summary Form should be faxed to Northwestern University within 72 hours at 312-503-0425, or in the manner specified by the Departments.

If the SASS provider determines that less restrictive resources and supports can meet the immediate needs of the child in the community, then crisis stabilization or intensive outpatient services can be utilized. These service requirements are identified in Topic CMH-202.2 Crisis Intervention and Stabilization Services.

If the SASS provider determines that the child is exhibiting symptoms and behaviors that present a danger to him/herself, others or property and the child cannot be managed safely and appropriately with intensive crisis intervention and stabilization services, then hospitalization is indicated. These service requirements are identified in Topic CMH-202.3 Hospitalization Services.

CMH-202.2 CRISIS INTERVENTION AND STABILIZATION SERVICES

Crisis intervention and stabilization services are activities to stabilize a child in a psychiatric crisis to avoid more restrictive levels of treatment and that have the goal of immediate symptom reduction, stabilization and restoration to a previous level of role functioning. Crisis intervention and stabilization services may be authorized for a period not to exceed 90 days.

The SASS provider will deliver crisis intervention and stabilization services to the

child and his/her parent, guardian or caregiver as necessary to resolve the immediate crisis and to stabilize the child's behavioral and emotional condition.

The SASS provider shall have a QMHP review all determinations to provide community-based crisis stabilization services within 24 hours of that determination.

When the SASS provider makes the determination to maintain a child in the community, the SASS provider will supply the child's parent, guardian or caregiver with an emergency number to access the SASS provider at all times.

The SASS provider shall develop a preliminary treatment plan for the initial provision of mental health services to the child, parent, guardian or caregiver and ongoing stabilization mental health services. This preliminary plan must be approved and signed by the parent, guardian or caregiver.

The SASS provider shall develop, coordinate and implement outpatient service alternatives when hospitalization is not warranted. These services shall include, but not be limited to, psychiatric consultation, intensive individual therapy, family therapy, behavior management, in-home therapeutic services and education.

The SASS provider shall have a psychiatric resource available either directly or through cooperative working agreements to provide consultation and medication management on a priority basis to those children who are receiving crisis intervention and stabilization services in-lieu of hospitalization.

The SASS provider must arrange a follow-up appointment with the child and parent, guardian or caregiver within 48 hours after the initial screening and assessment.

The SASS provider shall determine whether a child is currently receiving mental health services. If a child is receiving services, the SASS provider shall obtain the appropriate consent(s) and notify the provider of the screening intervention. For DCFS wards, use the CFS 600-3 Consent to Release Information form. Refer to Appendix CMH-8. The SASS screener and the current provider shall then have a case staffing and develop a coordinated plan for crisis and stabilization.

CMH-202.3 HOSPITALIZATION SERVICES

If a determination is made to hospitalize the child, the SASS provider shall assist and facilitate the child's admission to a psychiatric hospital. The SASS provider shall work with the parent, guardian or caregiver to select the most appropriate hospital for the child.

Children with SASS temporary eligibility do not have coverage for outpatient hospital Clinic A or Clinic B services or partial hospitalization services.

CMH-202.31 Guidelines for Hospital Selection

The following criteria shall be considered in the selection of a hospital:

The diagnosis and treatment needs of the child.

The treatment programs available in area hospitals as compared to the child's needs.

The proximity of the child's residence to the hospital facility.

The proximity of the child's home SASS provider to the hospital facility.

The child's hospitalization history and need for continuity of care.

For children under the age of 18:

- No child for whom DCFS is legally responsible and under the age of 18 may be hospitalized on an adult unit.
- For other SASS children, best practice suggests that no child under the age of 18 be admitted to an adult unit.

For youth 18 years of age or older:

- No youth for whom DCFS is legally responsible and who are 18 years of age or older may be hospitalized on a child and adolescent unit.
- For other SASS youth 18 years of age or older, best practice suggests they be admitted to an adult unit.

If no bed is available at a hospital and the hospital agrees **that the child should be admitted,** the hospital is responsible for locating another bed. Refer to 42 USC 1395dd(b), Emergency Medical Treatment and Active Labor Act of 1985.

CMH-202.32 SASS Provider's Role at Hospital Admission

The SASS provider must participate in the child's admission evaluation. The SASS provider may communicate verbally with the hospital if the need for psychiatric hospitalization is evident at the time of the initial screening and an emergency admission is required. Such communication shall include arrangements by which the SASS provider shall be informed immediately of the decision of the hospital staff concerning a child's admission.

The SASS provider remains responsible for coordinating the child's admission to a hospital, even if the recommendation is not to admit.

It is the responsibility of the SASS provider to do whatever possible to encourage and support the caregiver's involvement and participation in the admission process.

The SASS provider shall facilitate transportation for the hospital admission, if necessary. Prior approval must be obtained from First Transit, Inc. for all non-emergency transportation. Refer to CMH-201.2. Under no circumstance is a child to arrive at the hospital without a parent, guardian, caregiver or SASS provider present to meet the child and facilitate the admission.

The SASS provider will present or fax the CSPI summary page to the hospital prior to admission.

CMH-202.32.1 HealthSystems of Illinois (HSI) Screen Entry

The SASS provider is responsible for entering hospital admission information into HSI's web based system. The entry must include the following:

- hospital name,
- location,
- admission date,
- and discharge indicator.

This entry must occur within 24 hours from the first point of discharge planning. The SASS providers must enter admissions occurring over a weekend on the following Monday morning.

The SASS provider failing to make these entries will result in the hospital not getting paid.

CMH-202.32.2 Consent

The SASS provider shall obtain consents for the provision of SASS services and assist with consents for hospital admission. For DCFS wards, use the CFS 600-3 Consent to Release Information form. Refer to Appendix CMH-8.

SASS providers are required to complete the Uniform Screening and Referral Form (USARF) and the MH-6, Application by an Adult for Admission of a Minor for admission of a SASS client to State Operated Facilities (SOF). Refer to Appendix CMH-8.

CMH-202.33 SASS Provider's Role During Hospitalization

A primary goal of the SASS provider is to support and maintain the child's pre-hospital functioning and living arrangement. The SASS providers will be pro-active in helping to reduce the hospital stay by providing consultation and advocacy services, including working closely and cooperatively with the hospital team who is directing treatment.

The SASS provider shall offer supportive services to the child's parent, guardian or

caregiver to encourage their participation in treatment planning, visits to the child at the hospital, discharge planning, and pre-discharge home visits.

The SASS provider shall collaborate with the psychiatric hospital treatment team to ensure appropriate discharge planning.

The SASS provider shall advocate for children, actively participate in hospital staffings, and ensure continuity of care.

The SASS provider shall have an available staff to attend and participate in all staffings including, but not limited to, the initial 72-hour staffing, subsequent staffings and the discharge staffing.

The SASS provider shall document participation in the hospital staffings.

The SASS provider shall document participation in discharge planning and relay that participation to DPA or enter the information into the HSI web based system.

When a child must be transferred from one SASS provider to another SASS provider, and the child is hospitalized, the SASS provider completing the evaluation and the SASS provider of origin will discuss how to coordinate services while the child is hospitalized, including discussing and determining which SASS provider will attend the 72-hour hospital staffing. To assure continuity, it would be beneficial for both SASS providers to attend the staffing.

In some instances, due to significant geographical issues, attendance at the 72-hour hospital staffing by the SASS provider of origin may be problematic. It is expected that the receiving SASS provider will attend. In case of conflicts, it remains the responsibility of the SASS provider of origin to attend the 72-hour hospital staffing.

If a discharge from the hospital has not been issued, the referring SASS provider is responsible for providing follow-up with the parent, guardian or caregiver within 48 hours to facilitate the child's return.

CMH-202.34 Hospital-to-Hospital Transfer

There may be situations when a child will need to be transferred from one hospital to another to receive inpatient services. Transfer from one hospital where the appropriate psychiatric services are not available to another hospital where the services are available does not require prior approval by First Transit. If the transfer is facilitated between the physicians or psychiatrists at the respective hospitals, the child's home SASS provider will provide ongoing services, unless distance is prohibitive.

If distance is prohibitive, then the home SASS provider shall collaborate with the SASS provider in the new hospital's LAN to provide services to the child. The case

shall remain open with the home SASS provider since it is still involved with the family.

> The hospital receiving the child must call CARES to report the admission of the child via a transfer from another hospital.

A CARES referral will be made to engage the appropriate SASS provider for any child who is hospitalized in another state and is transferring to a hospital in Illinois or into a hospital within a contiguous county that borders Illinois. The SASS provider is expected to provide service coordination to facilitate the engagement of the child and family in SASS services. This coordination may occur via phone until the child is transferred. Once the child is transferred back to an Illinois, or bordering county hospital, the SASS provider must provide a non-emergency response SASS screening within 24 hours or prior to the child's discharge from the hospital.

Any child transferring into the DCFS CATU must have authorization from DCFS. This authorization must be faxed to CARES before the child is transferred.

Any child transferred to a Forensic bed must have prior authorization from the DHS Forensic Division.

> All transfers of SASS cases must be reported to CARES so that payment authorization can be entered into DPA's prior approval system. Without the authorization, payment will not be made.

CMH-202.35 Parent/Guardian Refusal to Accept Child Post-Discharge

The SASS provider shall assist the CCBYS provider and, if necessary, the DCFS Child Protection (DCP) staff to prevent children from being abandoned while in the hospital because of a lack of services or an inability by the family to identify services. The SASS provider's duties may range from assisting the CCBYS provider and/or providing services to facilitate the complete development of a service plan.

CMH-202.4 INTENSIVE AND OUTPATIENT SERVICES

Intensive and outpatient services are to be utilized when the decision has been made to not hospitalize a child or the child is discharged from inpatient treatment. Intensive and outpatient mental health services should be utilized to prevent a reoccurrence of the crisis and establish a plan for ongoing community-based services. The 90-day SASS eligibility starts at the time of the first crisis assessment. Extensions by the Departments may be granted on a case-by-case basis.

The SASS provider must provide and/or coordinate on-going treatment and provide general case management services necessary for successful post-hospitalization stabilization. The SASS provider's involvement in the intensive and outpatient

psychiatric component will be determined on a case-by-case basis made in coordination with the residential/group home placement and the child's caseworker.

The SASS provider shall deliver the necessary mental health services or link the child and family to mental health and allied services that can stabilize and maintain the child in his/her home, school and community.

SASS providers shall maintain **written documentation** of all treatment interventions, unusual incidents and sentinel events.

During the child's 90-day SASS approved period, the SASS provider may refer the child to another Medicaid mental health provider who is willing and able to follow the child's treatment plan. To refer to another Medicaid mental health provider, the SASS provider must call CARES and report the referral. Refer to CMH- 201.12. Payment for services to which a child is referred will be determined in conjunction with setting up the referral through a discussion with the receiving provider (e.g., community mental health providers may bill DPA directly for services provided during the eligibility period or the child may be referred to a program whose funding already provides for the services (e.g., via the DCFS System of Care program).

The SASS provider has the primary responsibility for pre-psychiatric hospitalization screening and general case management, coordination, communication and collaboration with the other providers including, as applicable, arranging transportation through First Transit.

The SASS provider shall develop and execute a plan to transition children at the end of the 90-day period. This process will include, but is not limited to, referrals to other outpatient services, social services, transitional services as well as adult mental health services.

CMH-202.41 SASS Provider-to-SASS Provider Transfer

To transfer a child to another SASS provider, the SASS provider who received the initial SASS referral must call CARES to register the transfer. Refer to CMH-201.12.

The referring SASS provider shall ensure continuity of care for the child and collaborate with the receiving SASS provider. The referring SASS provider shall make available a copy of treatment documents to the receiving SASS provider after obtaining appropriate consent from the parent, guardian or caregiver. For DCFS wards, use the CFS 600-3 Consent to Release Information form. Refer to Appendix CMH-8. The referring SASS provider must have documentation in its file that reflects the date of contact with the receiving SASS provider.

All transfers must be reported to CARES so that payment authorization can be entered into DPA's prior approval system. Without the authorization payment will not be made.

CMH-202.5 PSYCHIATRIC RESOURCE

Each SASS provider must have available a psychiatric resource either directly or via cooperative working agreements. The role of the psychiatric resource is to provide consultation on treatment issues, facilitate crisis stabilization with priority medication assessment and management if appropriate, facilitate utilization of intensive community-based services with ongoing medication management, and make referrals for specialty and laboratory testing when indicated. All children receiving SASS services shall have the opportunity for assessment, treatment or referral by a psychiatric resource.

The SASS provider shall have available a psychiatric resource to consult with the child's SASS provider or hospital treatment team as needed.

The SASS provider shall have available a psychiatric resource to provide medication management services within 14 days of a child's discharge from a psychiatric hospital.

The SASS provider shall have a psychiatric resource available to provide consultation and medication management on a priority basis to those children for whom intensive community services were put in place in lieu of hospitalization.

The SASS provider shall either utilize in-house resources or establish a relationship with an entity to provide medication management, consultation, laboratory referrals and specialized assessments.

CMH-202.6 PSYCHOTROPIC MEDICATION COVERAGE

All children receiving SASS services through the Departments' SASS program will have the ability to receive funding for a limited set of psychotropic medications during the 90-day SASS period. Refer to Appendix CMH-4 for a listing of covered medications.

The SASS provider shall inform the families of children receiving 90-day SASS services of the availability of funding for this limited set of psychotropic medications. Coverage for lab tests for medication prescription/monitoring is not available under the SASS program. However, for children with temporary eligibility, FLEX funds may be used for this purpose. Refer to CMH-203.6 for information on FLEX funds.

If the child is under the care of DCFS, consent must be obtained from DCFS by using CFS 431A. Refer to Appendix CMH-8. The CFS 431 A can be faxed to the Consent Unit at 312-814-4128 or contact the Consent Hotline at 1-800-828-2179. If there are any problems with obtaining consent, please contact the Consent Unit Supervisor at 312-814-1267 or 312-814-8600.

CMH-202.7 FAMILY RESOURCE DEVELOPER (FRD)

The SASS provider must have an identified FRD. The FRD is employed by the SASS provider and is a previous SASS consumer or a parent, guardian or caregiver of a child with serious emotional disturbance that has successfully navigated multiple child-serving systems. The FRD has the skills to provide support to other families, parents, guardians and caregivers and assist them in achieving the best possible outcomes for their child.

The FRD can also assist the SASS provider in all aspects of service delivery at the community as well as administrative levels. Refer to Appendix CMH-2 for additional information regarding the FRD.

CMH-202.8 TRANSPORTATION COORDINATION

The SASS provider shall coordinate transportation to all services for a child as indicated in his/her treatment plan. If transportation to mental/behavioral health services is an impediment to the child receiving the needed services, the SASS provider shall follow Chapter T-200, Handbook for Provider of Transportation Services. The handbook contains DPA's policy and procedures regarding non-emergency transportation.

CMH-202.9 SERVICE EXTENSION REQUEST

The SASS provider may request service extensions beyond 90 days. Such extensions shall be approved on a case-by-case basis with prior approval from the Departments.

CMH-202.91 Crisis Extension

A crisis extension may be requested if a child experiences a psychiatric crisis within 14 days of termination of SASS eligibility. The SASS provider will contact CARES to request the crisis extension. The Request for Extended SASS Services form is not needed for a crisis extension. CARES will conduct an acuity screening to determine if an extension should be granted. If approved, CARES will enter a 30-day eligibility period for the SASS provider who received the initial referral. If the extension is not granted, the SASS provider may request a non-crisis extension by following the guidelines in CMH-202.92 below.

CMH-202.92 Non Crisis Extension

A non-crisis extension may be requested within 14 days prior to or after termination of SASS eligibility. To request an extension of the 90-day SASS service period, a "Request for Extended SASS Services" must be completed along with a new CSPI. Refer to Appendix CMH-5a for a copy of the extension request form. The extension request form, the updated CSPI and all previously completed CSPIs must be

submitted. The Departments reserve the right to request additional information, as needed.

Disposition on the extension request will be made in three to five business days from the date the request is received by the Departments. If the extension is approved, confirmation will be sent to the SASS provider via fax and CARES will enter an additional 30-day eligibility period for the SASS provider who received the initial referral. The 30-day extension will also apply to any other provider who was authorized to render services on the last day of the 90-day eligibility period.

CMH-202.10 DISCHARGE AND AFTERCARE SERVICES FROM THE SASS PROGRAM

Discharge from the SASS program can occur through a service discharge or an eligibility discharge. Services can be reinstated for a child terminated by a service discharge, as long as the child's SASS eligibility has not ended.

CMH-202.10.1 Service Discharge

A service discharge may occur when one of the following applies.

No Clinical Necessity: It is determined by the SASS provider, and verified by a physician or LPHA, that there is no clinical necessity for SASS services.

Case Transferred: The child's case is transferred to another SASS provider.

Child Not Willing or Able: The child is no longer available to receive services or refused services in accordance with 59 Ill. Adm. Code, Part 132.20, Client's Rights and Confidentiality.

CMH-202.10.2 Eligibility Discharge

An eligibility discharge occurs when one of the following applies.

90-Day Services Provided, No hospitalization, No Extension:
Services have been provided for 90 days from the date **of the most recent referral for SASS services** and an extension is not necessary or approved.

90-Day Services Provided, Hospitalization, No Extension: Services have been provided for the maximum allowable 90-day period and an extension is not necessary or approved.

CMH-202.10.3 Discharge Process

Termination Childhood Severity of Psychiatric Illness (CSPI)

The CSPI will be completed and utilized as an outcome measure at the time of discharge. It is expected that the child's CSPI score will demonstrate an improvement in overall functioning at the time of service termination.

Discharge Summary

The SASS provider shall forward a written discharge summary describing the type and quantity of services provided to the child, the outcome of SASS services, the child's current status and treatment recommendations to the local community mental health center or other identified mental health or social service agent within 10 days of discharge from SASS services.

If the child is under the guardianship of DCFS, a written discharge summary describing the type and quantity of services provided to the child, the outcome of SASS services, the child's current, status, placement and treatment must be forwarded to the caseworker and residential facility within 10 days of discharge from SASS services.

If the child is not under the guardianship of DCFS, but resides in a residential or group home placement; a written discharge summary describing the type and quantity of services provided to the child, the outcome of SASS services, the child's current, status, placement and treatment must be forwarded to the residential/group home within 10 days of discharge from SASS services.

Upon discharge of a child from SASS services, the SASS provider will coordinate with the provider who will be providing the post-SASS services to ensure that the SASS Mental Health Assessment and Treatment Plan has been initiated prior to terminating SASS services.

CMH-203 SPECIALIZED SERVICES

The following are additional expectations of the SASS program.

CMH-203.1 SASS PROVIDER'S ROLE WITH CARES

The SASS provider is responsible for maintaining active and working emergency phone numbers, including secondary and tertiary emergency numbers. If a SASS provider needs to change a phone number that CARES is using, the number must be submitted in writing to <SASS@idpa.state.il.us>. The Departments will then inform CARES of any phone number changes.

The SASS provider is responsible for working proactively with CARES to resolve questions and/or problems with them.

CMH-203.2 SASS PROVIDER'S ROLE WITHIN THE COMMUNITY

The SASS provider shall provide education regarding resource development, and outreach to community agencies and users of the system, including but not limited to: LAN membership, pediatricians, schools, and other service agencies or providers.

CMH-203.3 SASS PROVIDER'S ROLE WITH DCFS

The SASS provider shall participate in case staffings as requested by DCFS staff, including Administrative Case Reviews (ACR) and court hearings (See 59 Ill. Adm. Code 132 for allowable activities for billing when participating in these meetings). Additionally, SASS staff may be requested to provide written reports for any case staffing including an ACR or court hearing.

CMH-203.4 SASS PROVIDER'S ROLE WITH CHILDREN IN RESIDENTIAL/GROUP HOME PLACEMENT

The SASS provider shall follow all protocols for providing the screening and immediate crisis stabilization and coordination if hospitalization is needed. The SASS provider's involvement in the intensive and outpatient psychiatric component will be determined on a case-by-case basis made in coordination with the residential/group home placement and the child's caseworker.

CMH-203.5 SASS PROVIDER'S ROLE WITH THE INDIVIDUAL CARE GRANT PROGRAM

These services are funded by DHS and billed through the DHS system. Refer to Appendix CMH-3

The Department of Human Services administers the Individual Care Grant Program. The General Provisions and Program Requirements can be found in 59 IL Administrative Code 135. Refer to Appendix CMH-8.

The SASS provider shall provide parents, guardians or caregivers with information about the availability of funding for children identified as severely emotionally disturbed (SED) and may meet criteria for eligibility under the Individual Care Grant (ICG) Program.

CMH-203.51 ICG Application

The SASS provider shall assist parents, guardians or caregivers with preparing and submitting the DHS ICG application packet.

The SASS provider shall inform the parents, guardians or caregivers of children eligible for ICG funding about the ICG program and assist in the selection of residential or intensive community-based services.

CMH-203.52 ICG Case Management and Support

The SASS provider shall provide case coordination services for a child who is awarded a DHS/ICG. Case coordination shall be provided for both community-based and residential services.

The SASS provider must serve as the fiscal agent for community-based ICG plans.

= The SASS provider must meet the data and fiscal requirements of DHS to bill and receive reimbursement for ICG application assistance and case coordination.

Appendix CMH-3 contains general information about the ICG program.

CMH-203.6 FLEX FUNDING

When using FLEX, it must be reported through the DHS system. Refer to Appendix B-20 of the DHS manual for further guidance.

The DHS/DMH has established FLEX as a resource that providers may access to provide formal and informal supports and services to families whose children require their mental health services. Funding these supports and services follows the CASSP Model for System of Care and utilizes local partnerships to enrich family and community life.

FLEX may be used for any child residing in the LAN and implemented in conjunction with the LAN wrap efforts, but does not require formal LAN involvement or approval. All use of FLEX funds must include documentation of collaborative community planning with the family and other relevant community systems.

CMH-203.61 Program Responsibilities

The SASS provider is charged with the responsibility of assuring utilization of the FLEX program in a manner that makes optimum use of available funds to meet the needs of children and their families. Guidelines have been developed in three areas to encourage the utilization of FLEX funds, administrative, clinical and fiscal.

Administrative

The SASS provider is responsible for establishing the process for spending the FLEX funds and for setting up a system of communication regarding their availability. Experience has proven that in agencies where the FLEX funds have been fully utilized, the direct clinical staff are well aware of dollars provided and the supports families find helpful.

The SASS provider is also responsible to make certain that DHS/DMH funded outpatient programs serving children (including child and adolescent mental health outpatient programs funded by DHS) are regularly informed of the availability of these funds and how to access them. There will not be a cap placed on the amount of funds that can be allocated to each child. Each approved request may be granted for a maximum time period of 90 days. This approved 90-day period is NOT the same 90-day period for SASS eligibility There should be a plan to terminate these services within 90 days, or find an alternate means of funding the therapeutic services. The responsibilities of SASS program administration include the following:

- Notify the SASS business office to anticipate receipt of funds from DHS/DMH.
- Identify a person in the SASS program to function as the FLEX coordinator, to coordinate the program and share program material.
- Provide training to clinical staff on the protocol for utilizing funds.
- Notify child and adolescent providers that interface with the SASS program of the availability of funds.
- Regularly notify clinical staff of the balance in the FLEX account.
- Evaluate use of funds on an ongoing basis.
- Identify barriers to utilization if funds are not being spent.

Clinical

The SASS provider shall play a key role in the utilization of FLEX funds. They must maintain a thorough knowledge of resources within the community in which funds can be expended. The SASS provider must also provide an accurate assessment of how these resources can most effectively be matched with the needs of the children. Some SASS providers may have a member designated to maintain data about available resources, in others all staff contribute to the collective knowledge SASS providers must ensure that line staff are aware of resources so that FLEX funds will be utilized. SASS providers also play an important role in resource development as referenced later in this document.

In assessing the needs of the child, it is important to ensure that the child and family are aware of the responsibility they have in utilizing the funds. For example, if funds will be used to enroll a child in a therapeutic recreation program the parent must be committed to ensuring that the child has transportation to get to the program, as transportation to these types of services are not covered by the SASS program. SASS programs that use these monies well will not observe an increased sense of dependency of families but will instead create stronger partnerships with families in achieving treatment goals. FLEX monies can create other natural supports for families, with FLEX funds providing a transition to existing or expanding community supports. SASS providers are responsible for how the fund usage is tied to a child's Individual Treatment Plan.

The clinical responsibilities of the FLEX funds include the following:

- Maintain knowledge of available resources in the community.
- Maintain awareness of fund availability.
- Assess a child's family needs for FLEX funds.
- Partner with families to identify opportunities and family responsibility in utilizing funds.
- Document the need for FLEX funding in the child's Individual Treatment Plan.
- Present a documented plan to FLEX coordinator.
- Assist families in obtaining resources.
- Evaluate and document the effectiveness of a FLEX plan.

Fiscal

The SASS provider is responsible for setting up a system to track and communicate the balance of the FLEX funds and for making the funds accessible in a timely manner.

The FLEX fiscal responsibilities include the following:

- Receive FLEX fund allocation from DHS/DMH and notify SASS administrative staff of receipt.
- Track the balance of FLEX funds and maintain a record of utilization.
- Establish a time efficient process for disbursement of funds.
- Report the end-of-year balance to DHS/DMH in a timely manner.

CMH-203.62 Development of Resources

Awareness and development of community resources is essential to utilizing FLEX funds in the care of children and families with serious emotional disturbances. The development of effective relationships with other child-serving agencies allows for creative problem-solving when designing behavioral interventions for the context in which a child's difficulties arise. Successful programs articulate the need to work with community agencies to expand the scope of their services so that children with emotional and behavioral challenges can be included.

Resources that will address the needs of children across all life domains should be considered. The following list provides examples of potential resources for the utilization of FLEX funds.

- Community recreation programs/park districts
- Religious institutions
- Camps/American Camping Association
- YMCA/YWCA
- Township/county programs
- Library programs
- Police department youth activities
- Psychological testing
- After school programs
- Community centers
- Home health organizations
- Community colleges
- 4H, Junior Achievement
- Short-term use of emergency psychiatric medication

SECTION II. BILLING AND REIMBURSEMENT REQUIREMENTS

CMH-204 BASIC PROVISIONS

For consideration for payment by DPA for SASS services, a provider enrolled for participation in the DPA Medical Programs must provide such services. Services provided must be in full compliance with both the general provisions contained in the Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein.

The billing instructions contained within this handbook are specific to the DPA paper forms. Providers wishing to submit X12 or NCPDP electronic transactions must refer to Chapter 300, Handbook for Electronic Processing. Chapter 300 identifies information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Department of Public Aid.

In addition to the handbooks, the SASS provider must be in compliance with 52 IL Administrative Code 130, 59 IL Administrative Code 132 and 89 IL Administrative Code 140. Refer to Appendix CMH-8.

CMH-205 PROVIDER PARTICIPATION

CMH-205.1 PARTICIPATION REQUIREMENTS

A provider that has entered into a contract for participation in the SASS program with the Departments must be enrolled to participate in the DPA Medical Programs.

The provider must be enrolled for the specific category of service for which charges are to be made.

The categories of service for which a SASS provider may enroll are:

34 – DMHDD Rehab Option Services
47 – DMHDD Targeted Case Management Services

Procedure: The provider must complete and submit the following:

- Form DPA 2243 (Provider Enrollment/Application)
- Form DPA 1413 (Agreement for Participation)
- HCFA 1513 (Disclosure of ownership and controlling interest)
- W9 (Request for Taxpayer Identification Number)

These forms may be obtained from the Provider Participation Unit. E-mail requests for enrollment forms should be addressed to:

PPU@mail.idpa.state.il.us

Providers may also call the unit at 217-782-0538 or mail a request to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

The forms must be completed (printed in ink or typewritten), signed and dated in ink by the provider, and returned to the above address. The provider should retain a copy of the forms. The date on the application will be the effective date of enrollment unless the provider requests a specific enrollment date and it is approved by DPA.

Participation approval is not transferable: When there is a change in ownership, location, name, or a change in the Federal Employer's Identification Number, a new application for participation must be completed. Claims submitted by the new owner using the prior owner's assigned provider number may result in recoupment of payments and other sanctions.

CMH-205.2 PARTICIPATION APPROVAL

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet listing all data on DPA computer files. Refer to Appendix CMH-7a. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, refer to Appendix CMH-7.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the DPA files. If any of the information is incorrect, refer to Topic CMH-205.4.

CMH-205.3 PARTICIPATION DENIAL

When participation is denied, the provider will receive written notification of the reason for denial.

Within 10 calendar days after the date of a participation denial notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the DPA action is being challenged. If such a request is not received within 10 calendar days, or is received, but later withdrawn, the DPA decision shall be a final and binding administrative determination. DPA rules concerning the basis for denial of participation are set out in 89 Ill. Adm. Code 140.14. DPA rules concerning the administrative hearing process are set out in 89 Ill. Adm. Code 104 Subpart C).

CMH-205.4 PROVIDER FILE MAINTENANCE

The information carried in the DPA files for participating providers must be maintained on a current basis. The provider and DPA share responsibility for keeping the file updated.

Provider Responsibility

The information contained on the Provider Information Sheet is the same as in the DPA files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found are to be corrected and DPA notified immediately.

Any time the provider effects a change that causes information on the Provider Information Sheet to become invalid, DPA is to be notified. When possible, notification should be made in advance of a change.

Procedure: The provider is to line out the incorrect or changed data, enter the correct data, sign and date the Provider Information Sheet with an original signature on the line provided. Forward the corrected Provider Information Sheet to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Failure of a provider to properly notify DPA of corrections or changes may cause an interruption in participation and payments.

DPA Responsibility

When there is a change in a provider's enrollment status or the provider submits a change, DPA will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to all payees listed if the payee address is different from the provider address.

CMH-206 REIMBURSEMENT

= Eligible services are those services defined in 52 Ill. Adm. Code 130, 59 Ill. Adm. Code 132 and 89 Ill. Adm. Code 140.

When billing for services or materials, the claim submitted for payment must include a diagnosis and the coding must reflect the actual services provided. Any payment received from a third-party payer or other persons applicable to the provision of services must be reflected as a credit on any claim submitted to DPA bearing charges for those services or items. (Exception: DPA co-payments are not to be reflected on the claim. Refer to Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures, Topic 114.1 for more information on patient cost sharing.)

CMH-206.1 CHARGES

Charges billed to DPA must be the provider's usual and customary charge billed to the general public for the same service or item. Providers may only bill DPA after the service has been provided.

CMH-206.2 ELECTRONIC CLAIMS SUBMITTAL

Any services that do not require attachments or accompanying documentation may be billed electronically. Further information concerning electronic claims submittal can be found in Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures, Topic 112.3.

Providers billing electronically should take special note of the requirement that Form DPA 194-M-C, Billing Certification Form, must be signed and retained by the provider for a period of three years from the date of the voucher. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies or other adverse actions. Form DPA 194-M-C can be found on the last page of each Remittance Advice that reports the disposition of any electronic claims. Refer to Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures, Topic 130.5 for further details.

Please note that the specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, providers should contact DPA in the same manner as would be applicable to a paper claim. It may be necessary for providers to contact their software vendor if DPA determines that the service rejections are being caused by the submission of incorrect or invalid data.

CMH-206.3 CLAIM PREPARATION AND SUBMITTAL

Refer to Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures, Topic 112, for general policy and procedures regarding claim submittal.

DPA uses an imaging system for scanning paper claims. The imaging system allows more efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendix CMH-6 for technical guidelines to assist in preparing paper claims for processing. DPA offers a claim scannability/imaging evaluation. Please send sample claims with a request for evaluation to the following address.

Illinois Department of Public Aid
Attention: Vendor/Scanner Liaison
201 South Grand Avenue East
Data Preparation Unit
Springfield, Illinois 62763-0001

CMH-206.31 Claims Submittal

Form DPA 1443, Provider Invoice, is to be used to submit charges. A copy of the form and detailed instructions for its completion are included in Appendices CMH-6 and CMH-6a.

All routine paper claims are to be submitted in a pre-addressed mailing envelope provided by DPA for this purpose, Form DPA 1444, Provider Invoice Envelope. Use of the pre-addressed envelope should ensure that billing statements arrive in their original condition and are properly routed for processing.

For a non-routine claim submittal, use Form DPA 1414, Special Approval Envelope. A non-routine claim is:

Any claim to which Form DPA 1411, Temporary MediPlan Card, is attached.

Any claim to which any other document is attached.

Should envelopes be unavailable, the DPA 1443, Provider Invoice can be mailed to:

Illinois Department of Public Aid
Post Office Box 19105
Springfield, Illinois 62794

For electronic claims submittal, refer to Topic CMH-206.2 above. Non-routine claims may not be electronically submitted.

CMH-206.4 PAYMENT

Payment made by DPA for allowable services will be made at the lower of the provider's usual and customary charge or the maximum rate as established by DPA. Refer to Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures, Topics 130 and 132, for payment procedures utilized by DPA and Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures, General Appendix 8 for explanations of Remittance Advice detail provided to providers.

CMH-206.5 SERVICE DEFINITION AND ACTIVITY CROSSWALK

A listing of allowable procedure codes by provider type is on the DPA Web site. Refer to Appendix CMH-8.

Paper copies of the listings can be obtained by sending a written request to:

Illinois Department of Public Aid
Bureau of Comprehensive Health Services
201 South Grand Avenue East
Springfield, IL 62763-0001

The Web site listings and the downloadable rate file are updated as needed, but minimally annually. Providers will be advised of major changes via a written notice. Provider notices will not be mailed for minor updates such as error corrections or the addition of newly created HCPCS codes.

CMH-206.6 NON-COVERED ACTIVITIES

The following activities are not reimbursable under the Medicaid Community Mental Health Services Program, either because they are not directly therapeutic, and/or because the cost associated with the activity was already taken into account in the rates paid for billable services:

- Services provided to children who (1) are not approved through CARES and (2) do not have an appropriate ICD-9-CM diagnosis.
- Services for which the agency is not certified.
- Services that do not meet service requirements specified by 59 Ill. Adm. Code 132, including staff that do not meet minimal qualifications for performing the service.
- More than one staff person per service delivered.
- Performance of a service that would normally be billable, but the total time expended is less than one-half billable unit (e.g., less than 7.5 minutes).
- Preparation required to perform a billable activity (e.g., gathering child files, planning activities, reserving space).
- Activities required to complete a billable service after the billable portion of the episode is concluded (e.g., completing case notes, returning file material, clinical documentation, billing documentation, etc.).
- Unavoidable down-time, including waiting for children prior to a billable activity or due to failure of children to attend billable sessions either on or off-site.
- Time spent building a relationship with a child when not providing a service defined by 59 Ill. Adm. Code 132.
- Personnel/management activities (e.g., hiring, staff evaluations, normal staff meetings, utilization review activities, and staff supervision).
- Staff training, orientation, and development.
- Clinical supervision.
- Observation of the child, or care-taking activities with the child while not actively performing another billable service.
- Any travel, with or without a child in the car, unless performing a service specified in the child's Individual Treatment Plan (e.g., individual counseling).

CMH-207 FINANCIAL REPORTING REQUIREMENTS

A SASS provider must submit a 6-month cost report by January 31 of the new calendar year using the Consolidated Financial Report (CFR) and covering the costs associated with the SASS program for the period of July 1 through December 31. Only the costs associated with the SASS services should be reported on this CFR. Any cost reporting on the use of SASS FLEX funds or ICG work should be reported separately to DHS/DMH.

A SASS provider shall submit three (3) copies of an annual Consolidated Financial Report (CFR) and three (3) copies of a certified independent audit report within 180 days of the end of the provider agency's fiscal year to the address identified below. **The Consolidated Financial Report must detail the SASS program and must be bound within the certified independent audit report. The independent auditor shall provide an opinion expressing the accuracy of the Costs and Revenues schedules of the Consolidated Financial Report.**

All seven (7) schedules of the Consolidated Financial Report must be completed for both the 6-month cost report and the annual cost report.

1. Agency Information Page
2. Program Names Schedule
3. Costs Schedule
4. Revenues Schedule
5. Service Units Schedule
6. Personnel Schedule
7. Contractual Schedule

Electronic copies of the Consolidated Financial Report and instructions, as well as a sample opinion are available online. Refer to Appendix CMH-8.

Mailing address for submission of certified independent audit reports and the Consolidated Financial Report is:

Office of Planning and Budget Development
Department of Children and Family Services
Mail Station 440
406 East Monroe Street
Springfield, Illinois 62701-1498

Questions regarding the audit and cost reporting requirements should be directed to Department of Children and Family Services at 217-785-2468.

CHM-208 MONITORING, CORRECTIVE ACTION AND SANCTIONS

CMH-208.1 MONITORING

The Departments will perform ongoing monitoring of a SASS provider's compliance with contract deliverables. The Departments will monitor a SASS provider's performance in all areas, including those detailed below. Monitoring activities, include, but are not limited to the following:

- Readiness Review: e.g., review of infrastructure, staffing, record keeping, systems capabilities including disaster recovery plan, and implementation plan, including quality assurance processes.
- Compliance with HIPAA rules, Mental Health and Developmental Disabilities Code and Mental Health and Developmental Disabilities Confidentiality Act.
- Coordination with and notification to DCFS, DHS or DPA, as needed.
- Deliverables and self-reporting, including report monitoring for accuracy, completeness and timeliness.
- CARES reports regarding a SASS provider's timeliness of performance requirements.
- Onsite review: desk audits, including review of policy and procedures; training materials; training sessions; staff qualifications; and clinical care record review, including review of CSPI, parent, guardian or caregiver consent and involvement in care plan, individualized treatment plan and treatment.
- Performance on all aspects of the SASS program, including SASS screening; timeliness and procedures; 90-day treatment period; participation in hospital treatment plans, discharge planning and follow-up, as appropriate; care coordination and referrals; participation in DCFS case reviews, staffings and court hearings, as appropriate; family resource developer; education/outreach to other service providers; and 90-day extensions.
- Timely interaction with the HSI, CARES, Departments and hospitals regarding admissions, staffings and discharges.
- Care coordination activities, including resource utilization and mental health follow-up, medical services (e.g., medication management, lab follow-up), intensive home-based services, referrals and linkages to other resources.
- Process to assist families with preparing and submitting Medicaid/KidCare applications.
- Process to assist families with ICG applications and a SASS provider's provision of case management and intensive community-based services.
- Process to assist CCBYS and child protection, as needed.
- SASS system of access, use and documentation of FLEX funds.
- Claims including analysis of services.
- Telephone contacts, including "cold calling."
- Customer satisfaction surveys.
- Complaint monitoring.
- Hospital feedback regarding SASS involvement.
- Trend analyses.

CMH-208.2 CORRECTIVE ACTION AND SANCTIONS

The threshold is 100 percent compliance in the required program components. Corrective action plans will be required within two (2) weeks of adverse findings as determined by the Departments. If not corrected, other sanctions may be applied as determined by the Departments, based on the provisions in the contract.